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MEMORANDUM

TO: Commissioner Koh and the Members of the Public Health Council

FROM: Donna Levin, General Counsel
Nancy Ridley, Assistant Commissioner
Carl B. Rosenfield, Deputy General Counsel

DATE: December 19, 2000

RE: Emergency Promulgation of 105 CMR 128.000 – Health Insurance Consumer Protection Regulations

I. INTRODUCTION

The purpose of this memorandum is to request the Public Health Council's (the "Council") approval for the emergency promulgation of 105 CMR 128.000 et. seq. Health Insurance Consumer Protection Regulations (Attached). These regulations implement the sections of Chapter 141 of the Acts of 2000 (An Act Relative to Managed Care Practices in the Insurance Industry) for which the Department has responsibility. Prior to developing the regulations it was necessary to research issues and seek and receive input from interested parties. This effort did not allow sufficient time to hold public hearings prior to the January 1, 2001 effective date of the statute. In order to assure a successful and timely implementation of the consumer protection provisions under the Department's jurisdiction, emergency promulgation is necessary and warranted.

II. BACKGROUND

Chapter 141 was signed into law by Governor Cellucci on July 21, 2000. The legislation established the Office of Patient Protection ("OPP") within the Department. Among other things, OPP is charged with developing regulations that implement four provisions of the new M.G.L. c.176O. Specifically, the four statutory provisions govern managed care carriers' internal grievance procedures, detail certain guarantees

of continuity care and specialty care referral and coverage, and establish a process for obtaining an independent external review where coverage is denied based upon a medical necessity determination.

As part of the process of developing the proposed emergency regulations Department staff contacted and met with representatives of a number of health plans, provider organizations and consumer groups. In this effort the Staff was assisted by the Mediation Group without whose invaluable contribution the task of developing these regulations would have been made much more difficult. Drafts also were reviewed by the Managed Care Oversight Board (the "Board") and the Advisory Committee which were established by Chapter 141. Finally, input also was received from the Division of Insurance as part of the coordinating process that the two agencies have been following.

All of the comments of the interested parties, the Board, and the Advisory Committee have been carefully reviewed and evaluated. In many cases revisions were made as the result of input received from these entities. On a number of issues Staff decided that it would be prudent to defer consideration of the comments until the public hearing process has been completed. Some comments were rejected because the suggested changes either would result in a substantial deviation from the statutory requirements or were not practicable.

III. THE REGULATIONS

The two principal areas of the regulations involve the internal grievance process and the opportunity for an external review. For the continuity of care and specialty care referral and coverage provisions the regulations merely carry forward the statutory language as set out in M.G.L. c. 176O, s.15. Likewise, the regulation sections dealing with medical decision making and carriers' medical necessity guidelines reiterate the statutory language of M.G.L. c, 176O, s 16. Finally, the regulations at 105 CMR 128.600 organize into one provision the various reporting requirements that are imposed by several different sections of Chapter 176O.

105 CMR 128.300 through 128.313 set out the requirements for carriers' internal grievance procedures. M.G.L. c. 176O, s.13 requires that grievances must be resolved within thirty (30) days of receipt. If a grievance is not resolved with the thirty (30) day period it is deemed resolved in favor of the insured. Currently, the internal grievance procedures used by many carriers and the standards for internal grievance procedures used by the National Committee on Quality Assurance contemplate processes of longer duration than mandated by the Massachusetts law. The proposed regulations take into account that there may be some delays in obtaining relevant medical records not in the possession of the carriers. These delays may inhibit compliance with the thirty (30) day requirement. Accordingly, the proposed regulations at 105 CMR 128.305 provide that the thirty (30) day period does not begin to run until the insured individual signs a written authorization for the release of medical records.

Chapter 176O defines the term grievance very broadly. Without further regulatory clarification, grievance could be construed to include every inquiry made by an insured to a carrier. This would result in calls, that are readily resolved to the satisfaction of the insured, being processed through the formal grievance system unnecessarily. Treating every inquiry as a grievance would result in increased expense to the carriers without any corresponding benefit to the insured parties. To prevent this anomalous result, the proposed regulations allow for the establishment of an informal inquiry process. Under this process, inquiries that are

resolved to the insured's satisfaction within three (3) business days would not be treated as complaints that require the use of the formal grievance mechanism.

The regulations, at 105 CMR 128.400 through 128.416, also provide a mechanism for handling external reviews. The external review process is limited to those denials, of otherwise covered services, that result from a carrier's adverse determination that the service was not medically necessary. The proposed regulations provide for the screening of requests for reviews to assure that they involve medical necessity determinations as opposed to items specifically excluded from coverage or administrative matters. Appropriate requests will be referred to one of the external review agencies under contract to the Department. The regulations establish notice and other procedural requirements and set standards for the external review agencies. Also included are provisions for expedited reviews where delay would pose a serious and immediate threat to the health of the insured.

IV. CONCLUSION

Following the Council's approval of the proposed emergency regulations, Staff will be conducting a series of five public hearings at various locations throughout the Commonwealth. These hearings will occur in early February and will be held in conjunction with the Division of Insurance, which also will be filing emergency regulations implementing its portions of Chapter 176O. Staff will review comments and testimony and revise the regulations as appropriate. Staff anticipates returning to the Council as soon as possible after the hearings for the approval of final regulations.